DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1161

June 25, 1985

TO: ALL CMSP COUNTY WELFARE DIRECTORS CMSP LETTER #85-4

REVISED CMSP MEDICAL CARE HEARING REQUEST, FORM CMSP 1175

In July, 1984, you were sent instructions for handling beneficary requests for state hearings regarding County Medical Services Program (CMSP) medical care problems (CMSP Letter #84-2). Enclosed with the instructions was a camera-ready copy of the "CMSP Medical Care Hearing Request", form CMSP 1175, which was to be reproduced and used by the county. The form CMSP 1175 has been revised and a supply of the revised form (sample enclosed) may now be ordered through the Department of Health Services' (DHS) Warehouse. The enclosed form DHS 2031 should be used to order these forms. The CMSP Medical Care Hearing Request, form CMSP 1175, provides instructions to beneficiaries to assist them in requesting state medical care hearings, either by telephoning the Department of Social Services' (DSS) Public Information and Response Unit at the toll-free number (1-800-952-5253), OR by completing a request form and mailing it to DSS at the address shown on the form. To ensure careful review of each complaint, the latter is preferable whenever possible.

To permit State staff to screen beneficiary complaints and provide quick resolution, the form CMSP 1175 requires complainants to provide specific information regarding their problems in obtaining CMSP medical care. Therefore, a copy of the form CMSP 1175 must be sent with each notice of action which informs CMSP applicants that they have been determined eligible to receive CMSP services. This means that the form is required to be sent at the time of initial eligibility determination and with the annual redetermination package. Also, copies are to be made available upon request whenever a beneficiary wishes to file for a medical care fair hearing. To comply with legal requirements, the form CMSP 1175, or the exact wording on the form, must be used in the hearing request. Please destroy your supply of the old form CMSP 1175 and used only revised form CMSP 1175 (1/85).

I appreciate your cooperation in ensuring that all beneficiaries receive timely notification of their right to a fair hearing and the proper procedures for filing a request. If you have any questions regarding the enclosed form and/or proper dissemination of the form, please call Linda McFarland of my staff at (916) 323-0503.

Sincerely,

Cecilia Lewis for

Michael L. Rodrian, Chief
County Medical Services Section
Office of County Health Services

Enclosures (2)

OCHS-2793:6/85

COUNTY MEDICAL SERVICES PROGRAM (CMSP)
MEDICAL CARE HEARING REQUEST

INSTRUCTIONS

If you are dissatisfied with any decisions regarding medical care under the County Medical Services Program (CMSP), you have the right to request a hearing by the State Department of Social Services. (If you are dissatisfied with any decisions regarding eligibility for the CMSP, please contact your county welfare department.)

Your request for a hearing may be written or oral. *Your request for a hearing must be made within 90 days of the date on which the problem occurred.* The State Department of Health Services will review your hearing request and may contact you.

To file a written request for a hearing about medical care, follow these steps:

1. Please fill in the information requested and provide your signature on the back of this form.
2. Send the completed and signed form to

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 6—100
Sacramento, CA 95814

To file an oral request for a hearing about medical care, call the Public Inquiry and Response Unit at 1-800-952-5253. (Toll-free number.)

You may have witnesses at the hearing.

You will receive a written copy of the State Department of Health Services' position two days before the hearing.

You will receive a written copy of the decision.

You have the right to be represented at the hearing by another person of your choice (an attorney, a friend, a relative, or other spokesperson). You may be able to receive legal advice by calling the nearest legal assistance/services agency.

INFORMATION PRACTICES ACT STATEMENT

The information requested on the back of this form will be used by the State of California to resolve your complaint regarding medical care provided under the CMSP. Completion of the form is voluntary, and the form should be submitted to the State Department of Social Services if you wish to request a fair hearing. All information you submit is confidential, and it will be provided only to the State Department of Health Services and your county welfare department. For more information regarding use of this information or access to your records, contact the Office of County Health Services, State Department of Health Services, 714 P Street, Room 523, Sacramento, CA 95814 [telephone (916) 323-0503].

(Over)

1. Request for Hearing (complete information below)

_____ ,daytime phone _____
Name

address _____ , hereby request a hearing of actions taken by the State Department of Health Services regarding benefits and services under the County Medical Services Program (CMSP).

2. Complaint (explain your complaint about medical care under CMSP. Attach additional sheets if necessary.)

3. Complaint Date(s) (enter the month/day/year the problem occurred.)

4. Name of the Health Care Provider (doctor, pharmacy, hospital) involved

5. Address	6. Daytime Phone Number
7. Name of Your County Welfare Department Worker	8. Phone Number
9. Beneficiary ID Number (enter your ID number located on the fourth line, upper left-hand corner of your CMSP card)	10. Date Valid

The information I have given here is complete and accurate to the best of my knowledge. The State Departments of Social Services and Health Services have my permission to obtain information about my case from the county welfare department and/or the health care provider.

11. Signature	12. Date

Article 9. Maintenance Need

0601. Maintenance Need -- General

The amount of income a person or family is allowed to retain for living expenses shall be the maintenance need for the members of the CFBU living in the home as determined in accordance with Section 0603.

0603. Maintenance Need -- Persons Living in the Home.

The maintenance need for the members of the CFBU living in the home shall equal the Medi-Cal maintenance need level for a family group of corresponding size.

0605 Maintenance Need Levels

Number of Persons in CFBU	Maintenance Need
1 person in all situations	$ 509
2 persons	$ 634
2 adults	$ 784
3 persons	$ 784
4 persons	$ 934
5 persons	$1,067
6 persons	$1,200
7 persons	$1,317
8 persons	$1,434
9 persons	$1,542
10 persons	$1,659

For each additional person add $11